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Nos. 84-495 and 84-1379

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

RICHARD THORNBURGH, *et al.*,
Appellants

v.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PENNSYLVANIA SECTION, *et al.*,
Appellees

EUGENE F. DIAMOND, *et al.*,
Appellants

v.

ALLAN G. CHARLES, *et al.*,
Appellees

On Appeal from the United States Courts of Appeals for the Third and Seventh Circuits

---

BRIEF *AMICI CURIAE* OF THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, THE AMERICAN ACADEMY OF PEDIATRICS, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AND THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF APPELLEES

Of Counsel:

KIRK B. JOHNSON
AMERICAN MEDICAL ASSOCIATION
535 N. Dearborn Street
Chicago, Illinois 60610
(312) 645-4600

R. MICHAEL MILLER
AMERICAN ACADEMY OF FAMILY PHYSICIANS
1740 West 92nd Street
Kansas City, Missouri 64114
(816) 333-9700

BENJAMIN W. HEINEMAN, JR.*
CARTER G. PHILLIPS
VINCENT F. PRADA
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 429-4000

NEWTON N. MINOW
JACK R. BIERIG
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000

SIDLEY & AUSTIN
Counsel for the Amici Curiae

* Counsel of Record

[Additional Counsel Listed on Inside Cover]

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

STEPHAN E. LAWTON
PIERSON, BALL & DOWD
1200 - 18th Street, N.W.
Washington, D.C. 20036
(202) 331-8566

JOEL I. KLEIN
ONEK, KLEIN & FARR
2500 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184

JOSEPH A. KEYES, JR.
ASSOCIATION OF AMERICAN
MEDICAL COLLEGES
One Dupont Circle, N.W.
Washington, D.C. 20036
(202) 828-0555

ANN E. ALLEN
AMERICAN COLLEGE OF
OBSTETRICIANS AND
GYNECOLOGISTS
600 Maryland Avenue, S.W.
Suite 300-East
Washington, D.C. 20024
(202) 638-5577

QUESTIONS PRESENTED

Amici American Medical Association, *et al.*, will address the following issues:

1. Whether Pennsylvania impermissibly infringes the woman's right of privacy by requiring her physician to communicate to her a specified litany of information concerning abortions and the abortion procedure.

2. Whether Illinois impermissibly infringes the woman's right of privacy by requiring her physician to inform her that a prescribed method of birth control causes "fetal death."

3. Whether Pennsylvania impermissibly infringes the woman's right of privacy by requiring her physician to disregard the emotional and psychological effects of the abortion technique on the woman and to select the technique that provides the fetus with the greatest chance of survival, even though that technique may pose a greater health risk to the woman.

4. Whether Illinois impermissibly infringes the woman's right of privacy by imposing criminal sanctions on a physician for failure to comply with a vague standard of care to protect a fetus based on either the "possibility" that a fetus is viable or that a fetus is "known to be viable."

5. Whether Pennsylvania's "second-physician" requirement for post-viability abortions contains a sufficiently clear emergency exception to comply with this Court's holding in *Ashcroft* v. *Planned Parenthood*, 462 U.S. 476 (1983).

6. Whether Pennsylvania impermissibly infringes the woman's right of privacy by requiring her physician to supply the State with reports concerning every abortion, which include descriptions of the bases for certain medical judgments.

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INTEREST OF *AMICI CURIAE*

Amici curiae are six major organizations of health care professionals. Each *amicus* shares in common an abiding dedication to promote the public welfare through

the maintenance of the highest professional standards and the provision of quality health care. *Amicus* American Medical Association ("AMA") is a private, voluntary, nonprofit organization of physicians. The AMA was founded in 1846 to promote the science and art of medicine and the improvement of public health. Today, its membership exceeds 234,700 physicians and medical students.

Amicus American Academy of Family Physicians ("AAFP") is a national professional association whose membership includes approximately 56,000 family physicians and medical students. AAFP's purposes include promotion of excellence in health care and in the delivery and care of newborn infants. *Amicus* American Academy of Pediatrics ("AAP") is a nonprofit Pan-American Association of approximately 24,000 physicians certified in the specialized care of infants, children and adolescents. The AAP's principal purpose is to ensure the attainment by all children of their full potential for physical, emotional and social health.

Amicus Association of American Medical Colleges ("AAMC") is a national professional organization whose membership includes approximately 127 medical schools, 400 teaching hospitals and 76 academic societies in the United States. AAMC's purposes include the advancement of medical education and the improvement of health care in the United States. *Amicus* American Psychiatric Association (APA) is the nation's largest professional association specializing in psychiatry, with a membership exceeding 30,000 physicians. APA's purposes include promoting the welfare of patients who require psychiatric services.

Amicus American College of Obstetricians and Gynecologists ("ACOG") is a private, voluntary, nonprofit organization of physicians who specialize in obstetric and gynecologic care. ACOG is the leading group of professionals providing health care to women; its 25,000 members represent approximately ninety percent of all ob-

stetricians and gynecologists practicing in the United States.[1]

Amici's interest in these cases stems from their desire to provide medical care of the highest quality, their dedication to good medical practice and their commitment to patients' freedom to seek and obtain needed medical care. To further these interests, physicians must be in a position to discharge their responsibility to provide care and treatment according to their best clinical judgment consistent with professional and ethical standards. *Amici*'s interest is not in debating the philosophical, ethical, moral or religious issues surrounding abortion. Indeed, their members hold widely divergent views on these issues, and *amici* take no position on these issues in this brief. *Amici*'s members do, however, share an interest in making certain that, when a patient does seek medical care and treatment, such as an abortion, state laws not impermissibly interfere with the physician's ability to exercise his or her best judgment in carrying out the patient's decision in the manner most suited to the patient's particular health needs.

The provisions of the Pennsylvania and Illinois statutes at issue in these appeals interfere with the exercise of a woman's right to seek and obtain wanted medical care, prevent her physician from exercising his best medical judgment in providing high quality medical care and create serious obstacles to sound medical practice. The outcome of these cases will directly affect the professional services *amici*'s members provide and the patients whom they serve. Accordingly, *amici* wish to present their views concerning the important issues raised in these appeals.[2]

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[1] ACOG is an appellee in *Thornburgh* v. *American College of Obstetricians and Gynecologists*, No. 84-495, and is filing a separate brief as a party in that appeal. Thus, it is joining this brief only with respect to the appeal in *Diamond* v. *Charles*, No. 84-1379.

[2] Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

I.

This Court has long recognized that the individual has a fundamental right, derived in important part from the concept of "liberty" in the Due Process Clause, to make highly personal choices affecting marriage and procreation. More recently, it has held that this right embraces a women's decision whether and how to terminate her pregnancy. Because abortion is a medical procedure, a necessary corollary to the woman's constitutional right to make a decision about terminating her pregnancy is the right to establish and maintain a doctor-patient relationship with a physician. *Roe* v. *Wade*, 410 U.S. 113 (1973); *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983). Despite the argument of the United States to the contrary, the principle of *stare decisis* requires reaffirmation of this fundamental privacy right, especially in light of *City of Akron*, in which the Court barely two years ago specifically underscored the importance and validity of the right.

In the nearly two dozen related cases handed down since *Roe* v. *Wade*, this Court has given content to the fundamental right by establishing a doctrinal framework which balances the woman's fundamental interest in making a personal medical treatment decision with the state's compelling interest in promoting maternal and fetal health. That framework was clearly articulated by the Court in *City of Akron*. First, the Court has established standards for determining when the fundamental privacy right has been infringed, thus requiring a state to satisfy the compelling interest standard of judicial review. Such infringement occurs when a state law interferes with a woman's decision whether or not to terminate her pregnancy or when a state law interferes with a physician's willingness or ability to enter into a physician-patient relationship with a woman considering an abortion, to

counsel the patient and to provide medically indicated care and treatment. Second, the Court has established a three-part compelling state interest test for laws that do infringe the woman's privacy right: the purpose of the state law must be to advance the state's compelling interests in maternal or fetal health; the specific means chosen must be "reasonably related" to those compelling health goals and thus consistent with sound medical practice; and those specific requirements must be tailored to the state's legitimate goals. In sum, the Court's decisions employ traditional constitutional standards applied in other contexts necessarily modified in this context to balance the privacy right to make a highly personal medical treatment decision against the state's compelling interests in maternal and fetal health.

II.

A. Pennsylvania's informed consent provision is unconstitutional. Although this Court has upheld a basic requirement that the physician must obtain the patient's informed consent, *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 67 n.8 (1976), it has held that state attempts to confine the physician's professional discretion as to how best to inform the patient concerning a medical procedure and its consequences infringe the privacy right. *Id.*; *City of Akron*, 462 U.S. at 445. Pennsylvania's compelled disclosures interfere with the physician's judgment and therefore trigger judicial scrutiny under the compelling interest test. The State's mandated disclosures to all patients seeking an abortion are inconsistent with accepted medical standards of individualized physician-patient communication and therefore are unconstitutional.

B. Illinois' "abortifacient" disclosure requirement is unconstitutional. The woman's right in consultation with her physician to employ methods of birth control is clearly part of the right of privacy recognized in *Gris-*

wold v. *Connecticut*, 381 U.S. 479 (1965), *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972), and *Roe* v. *Wade*, *supra*. The State of Illinois compels the physician to communicate that a birth control method which interferes with the development of a fertilized egg constitutes "fetal death." This requirement is calculated to, and in fact will, interfere with the patient's decision and with the physician's ability to provide medically relevant information to the patient. Compare *City of Akron*, 462 U.S. at 445. The State has no compelling interest in discouraging women from using birth control methods. Moreover, "fetal death" is not a medically accepted description of the effect of most, if any, birth control techniques. Finally, not every woman needs or wants to have this information supplied to her. *Id.*

C. The Illinois and Pennsylvania fetal treatment provisions are unconstitutional. All three provisions attempt to regulate late abortions which virtually always involve women facing serious health problems. Available abortion methods involve risks, both to the mother and to the fetus. Section 6(4) of the Illinois Abortion Law of 1975 requires the physician to choose the abortion technique that will best protect the fetus without increasing the mother's health risk whenever there is a "possibility" of fetal survival. This provision is unconstitutional under *Colautti* v. *Franklin*, 439 U.S. 379 (1979), and because the requirement is inconsistent with medical practice.

Section 3210(b) of Pennsylvania's 1982 Abortion Control Act requires the physician after the fetus is viable to choose the abortion method most likely to protect the fetus unless that method "significantly" increases the mother's health risk, which is defined expressly *not* to include emotional or psychological health. By preferring the fetus's health over the mother's, and by forcing the physician to disregard certain facets of the mother's condition, Pennsylvania attempts to further its compelling interest in fetal health in ways that this Court already has held are absolutely inconsistent with accepted medical practices. *See, e.g., Colautti* v. *Franklin*, 439 U.S. at 400; *Planned Parenthood* v. *Ashcroft*, 462 U.S. 476, 485 n.8 (1983) (Powell, J.).

Section 6(1) of the Illinois statute requires the physician to choose the abortion method that best protects the fetus's chance of survival, if the fetus is "known to be viable." Although the statute burdens the patient-physician privacy right by regulating the physician's treatment decision at a time of maximum danger to the pregnant woman, the State does seek to further its compelling interest in fetal health. But the State cannot justify this imposition of a general requirement on the physician's exercise of medical judgment in an individual case when he is planning and performing a late pregnancy abortion because such a requirement impermissibly increases the risk to the mother's health.

D. Pennsylvania's "second-physician" requirement for abortions of a viable fetus can only withstand constitutional scrutiny under this Court's decision in *Planned Parenthood* v. *Ashcroft*, if it contains a clear exception for emergency operations. The affirmative defense for medical necessities in Pennsylvania's law is not sufficiently clear to comply with the holding in *Ashcroft*.

E. Pennsylvania's reporting requirement is unconstitutional. Pennsylvania requires physicians to supply it with 14 items of information about each abortion and compels physicians to explain the bases for their medical judgments regarding certain treatment decisions. Some of those requirements are unnecessarily burdensome. *See Planned Parenthood* v. *Danforth*, 428 U.S. at 80-81. Moreover, the State has made no effort to explain concretely how this information is carefully tailored to its interest in promoting maternal health.

ARGUMENT

I. THIS COURT HAS ESTABLISHED A DOCTRINAL FRAMEWORK FOR IMPLEMENTING A WOMAN'S PRIVACY RIGHT TO MAKE A PERSONAL MEDICAL TREATMENT DECISION ABOUT TERMINATION OF A PREGNANCY IN CONSULTATION WITH A PHYSICIAN.

In its brief *amicus curiae*, the United States takes the highly unusual position of asking this Court to overrule a recent decision of the Court interpreting the Constitution—*Roe* v. *Wade*, 410 U.S. 113 (1973). The federal government argues that *Roe* v. *Wade* should be abandoned because the privacy right announced in that case cannot properly be derived from the Constitution and because legal standards for implementing the right do not exist. (U.S. Br. at 20-30.) But a general right of privacy has a long history in the jurisprudence of this nation and this Court, and the specific rights at issue here follow logically from precedents of this Court which the United States itself considers valid. Moreover, as emphasized in this Court's decision in *City of Akron*, this Court has developed a doctrinal framework for implementing a woman's right to make a personal medical treatment decision, in consultation with her physician, relating to procreation. This framework balances the individual's fundamental privacy right with the states' strong interests in maternal and fetal health.[3] Before addressing the specific provi-

[3] *Amici* recognize that reasonable people differ about how to balance the privacy right against the state's interest in maternal and fetal health, and in particular about whether the state has a compelling interest in fetal health before viability. This brief is premised on the fact that this balance has already been struck by the prior decisions of the Court. Given the diversity of views of their members, *amici* neither endorse nor oppose the Court's holding that the state's compelling interest begins at viability. As noted above, *amici's* interest is in ensuring that, when a woman seeks medical treatment, state laws do not impermissibly infringe on the ability of her physician to provide such treatment in the manner best suited to the patient's needs.

sions of state law at issue in these cases, *amici* will briefly discuss these important threshold matters.

A. The Fundamental Privacy Right Arises In The Context Of A Medical Treatment Decision.

1. This Court has long recognized that, as part of the "liberty" protected by the Constitution's Due Process Clauses, the Constitution guarantees to each individual certain areas or zones of privacy which remain free from unjustified government interference or intrusion, although the Constitution itself does not include an express right of privacy. Compare *Union Pacific Ry.* v. *Botsford*, 141 U.S. 250, 251 (1891), with *Stanley* v. *Georgia*, 394 U.S. 557, 564 (1969). The Court's privacy rulings rest on the theory that the constitutional text does not, on its face, specify all rights that warrant constitutional protection from executive or legislative intervention.[4]

[4] The concept of "liberty" in the Due Process Clause of the Fourteenth Amendment is a "broad" one. *Board of Regents* v. *Roth*, 408 U.S. 564, 572 (1972). For this reason, it has long been recognized as protecting certain personal choices. *See, e.g., Pierce* v. *Society of Sisters*, 268 U.S. 510, 534-535 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390, 399-400 (1923). Judicial recognition of an individual's relatively limited right, as part of personal liberty, to be free from unnecessary governmental intrusion because of the private nature of a personal decision hardly can be compared in scope, as the United States attempts to do (U.S. Br. at 29-30), to the judicial activism that marked the era of *Lochner* v. *New York*, 198 U.S. 45 (1905), and its progeny. *See Roe* v. *Wade*, 410 U.S. at 167-171 (Stewart, J., concurring).

Moreover, privacy is hardly the only value that has received constitutional recognition without being expressly specified in the constitutional text. For example, this Court has had little difficulty in deriving a constitutional right to travel. *Shapiro* v. *Thompson*, 394 U.S. 618 (1969). In addition, although "federalism" is nowhere mentioned in the Constitution, it is commonly assumed that the doctrine is part of the constitutional scheme and that judicial intervention is warranted if the federal legislative or executive branches intrude into state prerogatives. This Court has recognized as much. *See Coyle* v. *Smith*, 221 U.S. 559, 565 (1911); *Garcia* v. *San Antonio Metropolitan Transit Authority*, —— U.S. ——, 105 S. Ct. 1005, 1020 (1985).

The essence of the right to privacy is the concept that an individual in certain circumstances has a right to be let alone, *Olmstead* v. *United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), and that the individual must thus have "independence in making certain kinds of important decisions." *Whalen* v. *Roe*, 429 U.S. 589, 599-600 (1977). At the core of such a right are matters concerning marriage and procreation; the spectre of governmental agents unnecessarily interfering with such inherently private, individual decisions is antithetical to basic concepts of individual liberty in a free society. *See Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Loving* v. *Virginia*, 388 U.S. 1 (1967); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972). *See also Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942).[5]

2. Building on the precedent of constitutional protection for individual decisions affecting marriage and procreation, this Court in *Roe* v. *Wade* held that the "right of privacy . . . found in the Fourteenth Amendment's concept of personal liberty and restrictions upon state

[5] The United States seems to accept *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), as a legitimate decision on the ground that enforcement of a statute prohibiting the use of contraceptives would require wholly impermissible governmental prying into the private lives of individuals. (U.S. Br. at 20 n.6). Having accepted *Griswold*, however, the government's textual theory (U.S. Br. at 23-28) for rejecting *Roe* v. *Wade* collapses, because this Court did not locate the right recognized in *Griswold* in a specific constitutional provision and could not, as the United States suggests, have located it in the Fourth Amendment alone (because the Amendment guarantees procedural, not substantive, rights). The United States' brief therefore bears "witness that the *right of privacy* which passes for recognition here is a legitimate one." *Griswold*, 381 U.S. at 485 (emphasis added). Once the existence of a constitutional privacy right is, in effect, conceded, the United States' theory reduces to whether unnecessary governmental intrusion into a hospital operating room or a physician's examining room during a medically indicated obstetric or gynecologic procedure or examination is somehow inherently less repugnant than a similar governmental attempt to search a home.

action . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U.S. at 153. As this Court emphasized in *City of Akron*, 462 U.S. at 420 n.1, since *Roe* was decided in January 1973, the Court has affirmed the basic principle that a woman has a "fundamental right" to make the highly personal choice whether or not to terminate her pregnancy. *See, e.g., Connecticut* v. *Menillo*, 423 U.S. 9 (1975); *Planned Parenthood* v. *Danforth*, 428 U.S. 52 (1976); *Bellotti* v. *Baird*, 428 U.S. 132 (1976); *Beal* v. *Doe*, 432 U.S. 438 (1977); *Maher* v. *Roe*, 432 U.S. 464 (1977); *Colautti* v. *Franklin*, 439 U.S. 379 (1979); *Bellotti* v. *Baird*, 443 U.S. 622 (1979); *Harris* v. *McRae*, 448 U.S. 297 (1980); *H.L.* v. *Matheson*, 450 U.S. 398 (1981). Because this Court in *City of Akron* recently applied the *Roe* holding based, in part, on principles of *stare decisis*, there are now "especially compelling reasons" for reaffirming the woman's privacy right to make highly personal medical treatment decisions relating to procreation without unjustified governmental interference. *City of Akron*, 462 U.S. at 420 n.1.[6]

3. Because abortion is "inherently" and "primarily" a medical procedure, *Roe* v. *Wade*, 410 U.S. at 166, a corollary to the constitutional right to make a decision about termination of her pregnancy is the woman's right to establish and maintain a doctor-patient relationship with the physician of her choice. As this Court stated in *City of Akron*, 462 U.S. at 427 (citations omitted; emphasis added):

> [T]he full vindication of the woman's fundamental right necessarily requires that her physician be given

[6] Given the Court's recent adherence to *Roe* v. *Wade*, in express reliance upon principles of *stare decisis*, the United States' request for overruling that case now is particularly curious. It is, in effect, asking this Court not only to reconsider a constitutional precedent 13 years old, but also *City of Akron*, which was handed down barely *two* years ago. Indeed, certain passages of the brief read as if it were an untimely petition for rehearing of *City of Akron*. (U.S. Br. at 16-20.)

> "the room he needs to make his best medical judgment." . . . *The physician's exercise of this medical judgment encompasses both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion.*

The Court has, accordingly, given "consistent recognition" to the "critical role of the physician in the abortion procedure." 462 U.S. at 448 n.39.[7] Indeed, a dominant and recurring theme in this Court's abortion cases is that to effect the woman's constitutional right the physician must have freedom: (a) to enter into a physician-patient relationship; (b) to advise the patient properly; and (c) to perform appropriate medical procedures for her, consistent with accepted medical standards. *City of Akron*, 462 U.S. at 427; *Colautti* v. *Franklin*, 439 U.S. at 387.[8]

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[7] That the woman's right to decide whether to terminate a pregnancy encompasses the right to a physician-patient relationship—indeed takes root in a medical context—is reflected in *Connecticut* v. *Menillo*, 423 U.S. 9, 11 (1975). There the Court held summarily that "prosecutions for abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference."

This congruence between the physician's interest in exercising professional judgment on behalf of the patient and the woman's decision whether or how to terminate her pregnancy received concrete recognition in *Singleton* v. *Wulff*, 428 U.S. 106, 117 (1976), where a plurality of the Court held that physicians could assert the constitutional rights of their patients. Noting that the physician is "intimately involved" in the abortion decision and that the "woman cannot safely secure an abortion without the aid of a physician," the plurality concluded that "[a]side from the woman herself, therefore, the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, that decision." *Id.* at 117. *See also Whalen* v. *Roe*, 429 U.S. at 604 n.33.

[8] Thus, in *Roe* itself, the Court described the essential right in terms of the physician's ability to practice medicine on behalf of the woman—the physician, in consultation with the patient, must be "free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy must be terminated" and once the decision to abort is made, the abortion must be performed "free of interference by the State." 410 U.S. at 163. On the same day *Roe* was decided, the Court in *Doe* v. *Bolton*, 410 U.S. 179 (1973), struck down a Georgia state law requiring the approval of a hospital staff abortion committee before a physician could perform an abortion. The Court held that the procedure interfered with the physician's exercise of his best judgment and the physician's "right to administer" medical care. 410 U.S. at 197. *See also id.* at 208 (Burger, C. J., concurring); *Bellotti* v. *Baird*, 443 U.S. 622, 641 (1979).

In *Planned Parenthood* v. *Danforth*, *supra*, the Court analyzed the important role of the physician in consulting with the patient prior to any medical procedure. In upholding a State-imposed requirement that the consultation process must produce at its conclusion a signed, written consent form, the Court expressly recognized that too great an intrusion into the consultation process itself "might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." 428 U.S. at 67 n.8. The Court in *City of Akron* applied the *Danforth* dictum to protect the physician and patient from efforts by the government to intrude into the pre-decision consultation process. In striking down a law requiring the physician to recite a litany of abortion "facts," the Court reasoned: "It remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances." 462 U.S. at 443.

Similarly, once the woman in consultation with her attending physician has decided to undergo an abortion, her privacy right requires that substantial deference be accorded to the judgment of her physician in carrying out that decision. Thus, for instance, the fundamental decision whether a fetus is viable must be "a matter for the judgment of the responsible attending physician." *Planned Parenthood* v. *Danforth*, 428 U.S. at 64; *Colautti* v. *Franklin*, 439 U.S. at 396. And, the procedure of choice recommended by the physician is generally not subject to restriction by the state. 428 U.S. at 78. Ordinarily, the

state's health interests are fully protected by the duty of care the physician owes the patient and the ethical duties demanded by the medical profession. *Doe* v. *Bolton*, 410 U.S. at 199. *See also id.* at 207-208 (Burger, C.J., concurring).[9]

B. State Interference With the Woman's Choice Between Abortion And Childbirth Or With the Woman's Relationship With Her Physician Triggers Searching Judicial Examination Pursuant To The Compelling State Interest Test.

1. Having established that the right to decide whether to terminate a pregnancy, and the correlative right to a physician-patient relationship, is "fundamental" in a constitutional sense, this Court has further held that state "interference" or "infringement" of that right triggers a searching judicial examination pursuant to the compelling state interest test. *Roe* v. *Wade*, 410 U.S. at 155; *City of Akron*, 462 U.S. at 427. The requirement that a state justify "interference" or "infringement" of a fundamental constitutional right under a compelling state interest test is, of course, well-established in constitutional adjudication.[10]

Given the nature of the right, there are two types of infringement which trigger heightened judicial scrutiny. First, infringement occurs when state laws interfere with the *woman's* decisions whether to enter into a physician-

[9] In addition to the woman's right of privacy, physicians, of course, also have an independent right under the Due Process Clause of the Fourteenth Amendment to reasonable notice concerning precisely which of their actions violate the criminal laws of the state. Medicine is not an exact science, and therefore the state must carefully define the scope of criminal liability that it attempts to apply to various aspects of the practice of medicine. *Colautti* v. *Franklin*, 439 U.S. at 392-394. Moreover, criminal liability which is not properly defined may deter physicians from engaging in arguably protected activity to the detriment of the patient. *Id.* at 394.

[10] *See, e.g., Shapiro* v. *Thompson*, 394 U.S. 618 (1969); *Miami Herald Publishing Co.* v. *Tornillo*, 418 U.S. 241 (1974).

patient relationship with respect to abortion and whether or not to terminate her pregnancy. This Court has established certain standards for determining whether such an infringement has occurred: when a state abortion law imposes additional health risks on the woman; when a state law attempts to influence the woman's informed choice between abortion or childbirth through the physician-patient relationship; when a state attempts to force the woman to share decision-making authority with a spouse; or when a state law imposes costs on a woman unique to the abortion procedure.[11]

Second, infringement occurs when state laws interfere with a *physician's* willingness or ability to enter into a doctor-patient relationship, to counsel his patient and to provide medically indicated care and treatment.[12] Thus, there is infringement when a state law interferes with a physician's best medical judgment or is otherwise inconsistent with the state of medical knowledge and sound medical practice; when a state law threatens the doctor with sanctions which arise solely from abortion counseling and treatment; or when a state law imposes other burdens on a physician in the abortion context which could deter establishment of a physician-patient relationship or the

[11] See, *e.g.*, additional health risks—*Harris* v. *McRae*, 448 U.S. 297, 328 (1980) (White, J., concurring); influence woman's choice—*City of Akron*, 462 U.S. at 444; share decision-making authority—*Planned Parenthood* v. *Danforth*, 428 U.S. at 69; and costs unique to abortion—*City of Akron*, 462 U.S. at 435, 438, 447.

[12] Examples of how state intrusions operate illustrate pointedly why the privacy right extends both to the woman's decision *and* to the relationship between the patient and physician. Thus, regulations that affect the physician's practice of medicine will very often affect the woman's decision or ability to have an abortion. For instance, if the state declares unlawful the only abortion procedure that would be safe for a particular woman, then the state interferes with the physician's ability to practice medicine according to his best medical judgment and the woman will be effectively denied her right to make a decision whether to have an abortion.

discharge of professional obligations within that relationship.[13]

2. This Court has also held that certain types of governmental actions relating to abortion do not infringe the fundamental privacy right and thus do not trigger the compelling state interest test. First, there are laws which do not subsidize the abortion procedure at levels equal to a state subsidy granted to other medical procedures. The Court has held that refusal to finance an abortion with state or federal money,[14] or to make publicly-financed hospitals available for abortions, does not impose any additional burden either on the woman or her physician. In these circumstances, the woman "suffers no disadvantage" of constitutional significance by the government's refusal to extend benefits to her to which she otherwise can make no claim of Constitutional entitlement. *Maher* v. *Roe*, 432 U.S. 464, 474 (1977); *Harris* v. *McRae*, 448 U.S. 297, 314 (1980). Such a decision not to fund is valid so long as it is rationally-related to a legitimate purpose.[15]

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[13] See, *e.g.*, interference with best medical judgment—*Doe* v. *Bolton*, 410 U.S. at 195-200, *Planned Parenthood* v. *Danforth*, 428 U.S. at 64, *City of Akron*, 462 U.S. at 445, 450; inconsistent with state of medical practice—*Planned Parenthood* v. *Danforth*, 428 U.S. at 63-64, *City of Akron*, 462 U.S. at 448; sanctions solely from abortion role—*Colautti* v. *Franklin*, 439 U.S. at 390, 394, 397; other burdens—*Planned Parenthood* v. *Danforth*, 428 U.S. at 79-80 (record keeping requirement needs justification).

[14] *Harris* v. *McRae*, 448 U.S. 297, 314 (1980); *Williams* v. *Zbaraz*, 448 U.S. 358, 369 (1980); *Beal* v. *Doe*, 432 U.S. 438 (1977); *Maher* v. *Roe*, 432 U.S. 464 (1977).

[15] The United States misinterprets this Court's holdings in the abortion funding cases by relying upon them to support more expansive efforts by the state to regulate the abortion process directly. (U.S. Br. at 3.) The state's interest in favoring birth over abortion is only legitimate when the state's action does not interfere with the privacy right; otherwise, the two interests are mutually exclusive. *See Roe* v. *Wade*, 410 U.S. at 163-164. The state may favor childbirth over abortion in the context of dispensing benefits to which the woman has no constitutional entitlement, without interfering with the fundamental right. But, when it touches the highly personal issue of whether to terminate a pregnancy, such a preference by the state constitutes an infringement of the right. *See City of Akron*, 462 U.S. at 444 n.33.

Second, there are "minor regulations" which "may not *interfere* with physician-patient consultation or with the woman's choice between abortion and childbirth." *City of Akron*, 462 U.S. at 430 (emphasis added). Thus, by definition, a regulation is "minor" as a general matter when it does not "interfere" with or infringe the fundamental right under this Court's standards for determining such infringements. *See* pp. 14-16, *supra*. For example, a state law is "minor" in this constitutional context when it applies equally to abortions and to other medical procedures.[16] Even these "minor" state laws relating to, but not interfering with, the fundamental right must further "important health related state concerns" to be valid. 462 U.S. at 430.

C. The Compelling State Interest Test In The Abortion Context Has Three Distinct Elements All Of Which Must Be Satisfied If An Infringing Law Is To Be Valid.

If a state law infringes a fundamental right, then that law is "presumptively unconstitutional", *Harris* v. *McRae*, 448 U.S. at 312, *quoting Mobile* v. *Bolden*, 446 U.S. 55, 76 (1980), and cannot withstand judicial scrutiny unless the compelling state interest test is met. In the abortion context the compelling state interest test is comprised of three elements: the purpose of the state's law must be to advance the state's "compelling interests" in maternal or fetal health; the specific means chosen must be "reasonably related" to those compelling goals and thus consistent with sound medical practice; and those specific requirements must be carefully tailored to the state's legitimate goals. Under this Court's decisions,

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[16] *See Planned Parenthood* v. *Danforth*, 428 U.S. at 66-67; *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 486-490 (Powell, J.); *City of Akron*, 462 U.S. at 420.

failure to satisfy *any* of these elements is fatal to the state's effort to infringe the woman's fundamental right. *City of Akron*, 462 U.S. at 426-431.

In much fundamental rights adjudication, a holding of infringement will doom a law because the state has no constitutionally recognized "compelling interest" in such an infringing enactment. In the abortion context, however, this Court has clearly recogized two "compelling" goals which can justify regulation of the decision whether or not to terminate a pregnancy. Thus, the state may have a compelling interest in protecting the mother's health after the first trimester of a pregnancy.[17] *Roe* v. *Wade*, 410 U.S. at 154, 163; *City of Akron*, 462 U.S. at 428-429. Similarly, at the point of viability, the state has a compelling interest in preserving the potential life of the fetus, so long as the fetus's survival does not pose a threat to the life or health of the mother. *Roe* v. *Wade*, 410 U.S. at 162-163; *City of Akron*, 462 U.S. at 428. *See* note 3, *supra*.

Second, the presence of a compelling purpose does not ensure the constitutionality of the state's particular infringement of the fundamental privacy right. As the Court explained in *City of Akron*, 462 U.S. at 434, "the existence of a compelling state interest in health, however, is only the beginning of the inquiry." Thus, a state's requirements must be "reasonably relate[d]" to the compelling goals. *Roe* v. *Wade*, 410 U.S. at 163; *City of Akron*, 462 U.S. at 434. Typically, this second, "reasonably related" element of the test involves an inquiry into whether the state's requirements are consistent with accepted medical practices. Thus, when the state purports to regulate to further the health of the mother or fetus, it is obliged to adopt measures that have a reasonable medical basis. "The State's discretion to regulate . . . does not, however, permit it to adopt abortion regulations that depart from accepted medical practice." *City of Akron*, 462 U.S. at 431. *See Planned Parenthood* v. *Ashcroft*, 462 U.S. at 487 (Powell, J.); *Planned Parenthood* v. *Danforth*, 428 U.S. at 78.[18] This rule embodies the common sense proposition that, if a state is to further a health related goal, *i.e.* maternal health, it must use accepted medical means in doing so. *See City of Akron*, 462 U.S. at 431.

Third, state laws that interfere with or burden the right must be carefully tailored to the state's objective. *See Roe* v. *Wade*, 410 U.S. at 165; *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485 n.8; *City of Akron*, 462 U.S. at 438. The law must, in other words, not be overbroad and must, therefore, advance the compelling state interest without any additional and unnecessary interference with the fundamental right. *City of Akron*, 462

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[17] The state's interest in maternal health was held to be compelling at the end of the first trimester in *Roe* v. *Wade* because "mortality in abortion may be less than mortality in normal childbirth." 410 U.S. at 163. In *City of Akron*, this Court retained the beginning of the second trimester "as the approximate time at which the State's interest in maternal health becomes sufficiently compelling to justify significant regulation of abortion." 462 U.S. at 429 n.11. But, as noted immediately below, although the state's compelling interest in promoting maternal health begins at the end of the first trimester, a second trimester regulation to achieve that end will only survive judicial scrutiny if it satisfies the second element of the compelling state interest test and is consistent with accepted medical practice. *Id.* (Second trimester regulations must have "reasonable medical basis.")

[18] For instance, in *City of Akron* the Court held that the City's requirement that all second-trimester abortions be performed in a hospital was unconstitutional, because the practices of the medical profession had advanced to the point that such abortions could be performed safely and were being performed routinely in out-patient clinics. The City was therefore obliged to follow the accepted medical practice when it attempted to regulate directly the physician's medical practices in a way that in turn affected the patient's decision whether to seek treatment. 462 U.S. at 437.

U.S. at 438.[19] Thus, for example, the state has a compelling interest in the health of the woman after the first trimester, but in promoting that interest, the state cannot require the abortion to occur only in a hospital, regardless of the patient's condition. *City of Akron*, 462 U.S. at 437. It can, of course, regulate out-patient clinics to ensure that they are capable of responding to complications that might commonly occur. In this way the state protects its interest without undermining the physician's judgment about how best to treat the particular patient.[20]

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This framework established by the Court's abortion decisions is not the product of a series of *ad hoc* judicial responses to specific attempts by some states, often the same ones repeatedly, to regulate various facets of the abortion process. Rather, consistent with sound traditions of constitutional adjudication, the Court has proceeded on a case-by-case basis to define the contours of the right. Its decisions employ the traditional constitutional standards applied in other contexts with necessary modifications made to adjust both to the unique medical context implicated by the personal decision to terminate a pregnancy using *medical* procedures and to the state's compelling interest in maternal and fetal *health*. Although those standards may require the Court to engage in some difficult line drawing within the interstices of the framework, those interstitial judgments are no more

[19] This is also traditionally required when other fundamental rights are infringed by governmental action. *See, e.g., Aptheker* v. *Secretary of State*, 378 U.S. 500 (1964); *Cantwell* v. *Connecticut*, 310 U.S. 296 (1940).

[20] Although the Court in *City of Akron* relied heavily upon the effect of the hospitalization requirement on the woman's ability to afford an abortion, in our view it could also have relied upon the intrusion into the physician's judgment as to the best setting in which to perform the medical procedure.

difficult than the problems posed in applying other constitutional provisions in a modern era. Compare *Katz* v. *United States*, 389 U.S. 347, 352 (1968) (importance of accommodating constitutional guarantees to changing technology). That certain concepts in the Court's framework—for example, maternal health or fetal viability—are defined with reference to contemporary standards of social or medical science is hardly unusual or problematic.[21] Thus, if fetal viability occurs earlier in a pregnancy because of medical advances, then the state's compelling interest in protecting fetal health will simply be triggered sooner. *Cf., City of Akron*, 462 U.S. at 456-457 (O'Connor, J., dissenting).

In sum, this Court's decisions demonstrate that, in the years since *Roe* v. *Wade*, the Court has developed a set of legal standards to guide state and local governments and lower federal courts in deciding where the boundaries of the privacy right lie. That state legislatures may continue to explore the limits of those boundaries is no rea-

[21] In *Addington* v. *Texas*, 441 U.S. 418, 430 (1979), for example, the Court unanimously established the due process standards for involuntary civil commitments based on the state of medical practice at the time. The Court expressly relied upon "practical considerations" arising from the nature of psychiatry in shaping its burden of proof standard. 441 U.S. at 434. Simply because the Court similarly applies standards in the abortion context to take account of "practical" medical considerations does not, *per se*, cast any doubt upon the Court's approach.

In addition, this Court routinely has relied upon social science materials and concepts in resolving complicated constitutional issues in a wide range of cases. *See, e.g., Brown* v. *Board of Education*, 347 U.S. 483, 494 n.11 (1954). Thus, for instance, political science analyses have been utilized in applying the one-person-one-vote principle of the Fourteenth Amendment, *see, e.g., WMCA, Inc.* v. *Lomenzo*, 377 U.S. 633, 645 n.9 (1964), and economic analysis has been instrumental in deciding commerce clause cases, *see, e.g., Polar Ice Cream & Creamery Co.* v. *Andrews*, 375 U.S. 361, 378 n.11 (1964).

son to abandon them. Instead, the Court should reaffirm its commitment to the woman's right in consultation with her physician to make fundamental, personal decisions about medical treatment relating to procreation without unjustified governmental interference.

II. THE STATE LAWS AT ISSUE IN THESE APPEALS ARE UNCONSTITUTIONAL.[22]

Application of the Court's doctrinal framework renders the state laws at issue in these cases unconstitutional. Indeed, certain provisions are invalid as directly in conflict with prior holdings of the Court.

A. Pennsylvania's Informed Consent Provisions Are Unconstitutional.

Section 3205 of Pennsylvania's 1982 Abortion Control Act, 18 Pa. Cons. Stat. Ann. § 3205 (Purdon 1983), lists certain information that the physician must recite to each woman as part of the process of obtaining her informed consent to the aborton procedure. This informa-

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[22] Appellants in both cases raise a number of procedural issues including jurisdiction and mootness. *Amici*, with one exception discussed immediately below, do not address these issues but proceed as if all of the substantive issues are before the Court.

Pennsylvania has presented an issue concerning its parental consent statute for minors seeking abortions. 18 Pa. Cons. Stat. Ann. § 3206 (Purdon 1983). The court of appeals enjoined enforcement of the provision until the State Supreme Court adopted rules to implement the provision for judicial review of the minor's ability to give consent to the procedure. Pennsylvania's argument in this Court now turns largely on rules recently adopted by its Supreme Court which obviously were not considered by the lower courts. (Pa. Br. at 76-77.) Because the court of appeals' disposition of this issue was clearly correct at the time of the decision, *amici* submit that that decision should be affirmed. *Amici* believe the Court should dispose of this issue without considering the new rules *de novo*; we thus take no position on the constitutionality of those rules.

tion includes, *inter alia:* the fact that the woman may suffer unforeseeable and detrimental physical and psychological consequences from the abortion, the medical risks associated with full-term pregnancy, and the "probable gestational age of the unborn child." The physician or his agent also must inform the mother that, if she carries the child to term, the mother may qualify for state or private financial assistance and would be entitled to child support from the father. § 3205(b).

In addition, the woman must be offered printed materials prepared by the State. 18 Pa. Cons. Stat. Ann. § 3208 (Purdon 1983). The printed materials will describe the developing physical characteristics of the fetus in two-week gestational increments. These materials also must contain a statement that the State "strongly urges" the woman to contact listed agencies offering alternatives to abortion before she consents to the procedure.

1. *Medical Background.* In order to understand how Pennsylvania's informed consent provision interferes with the physician-patient consultation process, it is necessary first to understand how that process works. Consultation is the method of ensuring that each patient gives a knowing and voluntary informed consent to a medical procedure. The doctrine of informed consent is itself rooted in notions of patient autonomy and the uniqueness of each patient's needs. *See, e.g., Canterbury* v. *Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); E. Cassell, Talking With Patients 4-5 (1985); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. Rev. 628, 630 (1970). Just as some patients wish to be informed about every conceivable complication, no matter how remote, that may result from a medical procedure, others find such information frightening and would prefer to be spared the details. *See, e.g.*, Laufman, *Surgical Judgment*, in Christopher's Textbook of Surgery 1459 (L. Davis 9th ed. 1968);

Nehemiah, *Psychological Aspects of Surgical Practice*, in Surgery: A Concise Guide to Clinical Practice 9 (G. Nardi & G. Zunidema 3d ed. 1972). As the Court pointed out in *City of Akron*, "it is clear that the needs of patients for information and an opportunity to discuss the abortion decision will vary considerably." 462 U.S. at 448 n.38. *See also Canterbury* v. *Spence*, 464 F.2d at 789; *Sard* v. *Hardy*, 281 Md. 432, 443, 379 A.2d 1014, 1022 (1977).[22]

The informed consent doctrine thus stresses that the degree and kind of information to be conveyed must differ with the patient and the procedure; no universal list of information can provide each patient with proper information. For that reason, the decision about what specific information should be disclosed to the patient must be left to the physician's discretion. *See* 1 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 18-39 (1982).

2. *Infringement.* This Court previously considered whether informed consent provisions infringe the woman's fundamental right in *Planned Parenthood* v. *Danforth* and *City of Akron*. The Court in *Planned Parenthood* held that the state's law requiring the physician to obtain a written informed consent form signed by the patient did not infringe the fundamental right. But the Court warned against specific structuring of the informed consent process by the state. 428 U.S. at 67 n.8. In *City of Akron*, the Court found the City's attempt to compel the physician to communicate specific information about abortions and their procedures an interference with the fundamental right.[24] In rejecting the City's attempt to structure the physician-patient dialogue, the Court repeated the warning it had issued in *Danforth* "against placing the physician in . . . an 'undesired and uncomfortable straightjacket.'" 462 U.S. at 445. Thus, this Court has plainly indicated that attempts by the state to dictate precisely what information must be included as part of the consultation process interfere with the privacy right.[25]

[22] For example, when excessive disclosure would result in anxiety, fear, emotional distress or even increased physical pain, physicians may decide in the exercise of their professional judgment to tell their patient no more than she wishes to hear. *See, e.g., Roberts* v. *Wood*, 206 F. Supp. 579, 583 (S.D. Ala. 1962) (disclosure of risks of "a technical nature beyond the patient's understanding" may cause "anxiety, apprehension, and fear . . . [with] a very detrimental effect on some patients"); *Woolley* v. *Henderson*, 418 A.2d 1123, 1130 (Me. 1980) (the doctor must decide "whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy"; "full disclosure under some circumstances could constitute bad medical practice"); *Cobbs* v. *Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (*en banc*) (a patient has a right to decline to be informed about the risks of a proposed medical procedure). *See generally* J. Katz, Experimentation with Human Beings 540-588 (1972); Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision-making*, 1979 Wis. L. Rev. 413, 429.

[24] Both Pennsylvania (Pa. Br. at 71) and the United States (U.S. Br. at 8) rely heavily upon the Court's dictum in *City of Akron* that certain required information, such as the fact the woman is pregnant, that she may be eligible for state assistance and the gestational age of the fetus, "certainly is not objectionable." 462 U.S. at 445 n.37. But the Court did not state that it is *constitutional* for the state to interfere with the physician-patient relationship by compelling these or any disclosures. It merely found that these "facts" were not "objectionable," the way other Akron provisions were because these did not discourage a woman from having an abortion. The Court was not required to and did not say that it was going beyond *Danforth* which held only that the state can, without dictating the content of the form, properly require a written consent form signed by the patient.

[25] The State argues (Pa. Br. at 65) that because it did not *intend* to discourage abortions, its provision must be constitutional under *City of Akron*, in which the Court held, *inter alia*, that the City's intent to discourage abortions made its informed consent law unconstitutional. 462 U.S. at 445. The State reads too much into the discussion of intent in *City of Akron*. The Court did not adopt a subjective "intent" test as a necessary element of an infringement

In light of the individualized nature of the consultation process, Pennsylvania's required disclosures strike directly at the protected relationship between the woman and her physician by attempting to structure the dialogue between them. The State seeks to dictate that certain topics and information must be covered in consultation with every patient, regardless of the physician's best judgment. It also forces the physician to act, in effect, as the agent of the State; by emphasizing unforeseen risks of abortions and by recommending that the woman postpone her decision, the physicians are being forced indirectly to encourage all their patients to decide not to have an abortion.[26] Sections 3205 and 3208 are not "minor" obligations that would typically be applied to any other medical procedure. These provisions constitute infringement of the fundamental right because they are an attempt by the State to influence the woman's choice and directly burden the physician's exercise of medical discretion. *See, e.g., Roe* v. *Wade*, 410 U.S. at 165-166; *Singleton* v. *Wulff*, 428 U.S. at 128 (Powell, J.).[27]

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inquiry. It merely found that the City's intent was obvious and unconstitutional. Under the analysis outlined previously, the Court also must focus on the effect of the state's law which plainly interferes with the physician-patient relationship in the pre-decision, consultation process. In any event, by requiring more disclosures concerning the risks of abortion than the risks of childbirth and by requiring the physician to offer material that "strongly urges" the woman to consider postponing her decision, Pennsylvania manifestly intends, just as much as Akron did, to discourage the woman's exercise of her constitutional right.

[26] Instead of using its resources to inform women through a public forum about what state-supported options are available, if the woman chooses to carry her pregnancy to term, or to express generally the State's views concerning childbirth, the State enlists the physician as its agent. Thus, the State improperly manipulates the patient-physician relationship so as to influence the patient's basic decision. *See* note 28, *infra*.

[27] The United States appears to argue (U.S. Br. at 8) that the information requirement is permissible because physicians are free

2. *Compelling Interest Analysis.* To withstand constitutional scrutiny, the State must demonstrate that communication to the patient of State-mandated information is consistent with accepted medical practices and is narrowly tailored to further Pennsylvania's only asserted goal—promotion of maternal health. This it cannot do. In the first place, the State's interest in the mother's health, which could justify the intrusion into the physician-patient relationship, is not compelling until at least after the first trimester. Thus, the required disclosures do not advance any compelling interest prior to that time.

In addition, it is clear that Pennsylvania's informed consent requirement is not reasonably related to maternal health because it is inconsistent with accepted medical practices. As explained previously, good medical practice demands that patient and physician decide together on treatment based on the specific needs of *each* patient. "[E]thically valid consent is a process of shared decisionmaking based upon mutual respect and participation, not a ritual to be equated with reciting . . . the risks of particular treatments." 1 *Making Health Care Decisions* 2; E. Cassell, Talking with Patients 4-5 (1985).[28] *See City of Akron*, 462 U.S. at 448 n.38.

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to supply the patient with any additional, truthful information they wish. But this is no answer to the argument that the State's requirements interfere with the fundamental right. The State has already artificially modified the patient-physician relationship by forcing discussions into directions that, in the physician's judgment, may not be helpful to a particular patient and may affect the trust and confidence of the patient in her physician. Nor does the physician's right to respond justify the infringement. A mere opportunity to undo the damage cannot constitute a compelling interest required to justify the regulation. Moreover, the federal government's argument was at least implicitly rejected by this Court in *City of Akron*; the physicians in that case were equally free to attempt to rebut the "litany" of "facts" required by the City.

[28] Indeed, the recent Presidential Commission indicted such recitations of medical risks as damaging both to the patient and the patient-physician relationship:

Pennsylvania mandates a hollow ritual; among other things, it forces physicians to discuss as a "fact" unforeseeable "detrimental physical and psychological" risks of abortion that they may regard as wholly irrelevant to the patient. Compare *City of Akron*, 462 U.S. at 445.[29] Moreover, this type of disclosure may cause the woman unneeded and unwarranted anxiety about the procedure and thereby serve only to complicate her condition. By discouraging the woman from having an abortion, the required disclosures may also increase her health risks. For these reasons as well, the required disclosure is not reasonably related to the State's goal of promoting maternal health.

It follows, of course, that the Pennsylvania statute also cannot satisfy the "carefully tailored" requirement of the compelling interest test because the State requires all women to receive certain information, regardless of whether it will be medically beneficial to them. In addi-

> . . . Patients' interests are not well served by detailed, technical expositions of facts . . . reciting 'all the facts' in a blunt, insensitive fashion can . . . destroy the communication process, as well as the patient-professional relationship itself. 1 *Making Health Care Decisions* 71.

[29] *City of Akron* undermines the State's heavy reliance upon *Planned Parenthood* v. *Fitzpatrick*, 401 F. Supp. 554 (E.D. Pa. 1975), *aff'd mem.*, 428 U.S. 901 (1976), as requiring reversal on the informed consent issue. In the first place, the requirement in the earlier Pennsylvania Act, which still remains in the provision at issue here, that the *physician* must supply certain information to the patient makes the provision plainly unconstitutional under *City of Akron*. Moreover, *City of Akron* provides the appropriate analytical framework for this issue. Not one judge on the Third Circuit in this case, including Judge Adams who wrote the opinion for the court in *Fitzpatrick* on the informed consent issue, even mentioned *Fitzpatrick* as relevant. Instead, all of the judges who wrote below analyzed the issue solely in terms of this Court's plenary decision in *City of Akron*. Accordingly, the Court's summary affirmance, which is in any event entitled to considerably less precedential weight than an opinion on the merits, *Edelman* v. *Jordan*, 415 U.S. 651, 671 (1974), is entitled to no weight when it already has been superseded by this Court upon subsequent plenary review of the issue.

tion, the State's *required* disclosures about unforeseeable risks to the woman are "abortion regulations designed to influence the woman's choice between abortion or childbirth" which this Court already has held are not carefully tailored to the State's legitimate goal of promoting maternal health and thus cannot justify the State's intrusion into the physician-patient relationship. *City of Akron*, 462 U.S. at 444. Finally, Section 3205(a) unequivocally requires the *physician* to supply information about health risks, thus preventing other qualified personnel from doing so. This Court in *City of Akron* clearly held that such a requirement is overbroad, 462 U.S. at 447-449, and therefore Section 3205(a) is unconstitutional for this additional reason.

B. Illinois' Informed Consent Provision Is Unconstitutional.

Section 2(10) of the Illinois Abortion Law of 1975, Ill. Rev. Stat. ch. 38, ¶ 81-22(10) (1983), defines "abortifacient" as any instrument, medicine, drug or any substance or device which is known to *cause fetal death* . . . whether or not the fetus is known to exist when such substance or device is employed" (emphasis added). Section 11(d) of the Illinois Abortion Law of 1975, Ill. Rev. Stat. ch. 38, ¶ 81-31(d) (1983), provides:

> Any person who prescribes or administers any instrument, medicine, drug or other substance or device, which he knows to be an abortifacient, and which is in fact an abortifacient, and intentionally, knowingly or recklessly fails to inform the person for whom it is prescribed or upon whom it is administered that it is an abortifacient commits a Class C misdemeanor.[30]

[30] Although the reference to "fetal" death could be interpreted to limit the provision to an ordinary abortion performed during the first trimester, the term "fetus" is defined to include a fertilized egg. Section 2(a) of the Illinois Abortion Act of 1975, Ill. Rev. Stat. ch. 38, ¶ 31-32(g) (1983). Thus, the provision was clearly intended to regulate various forms of birth control.

1. *Medical Background.* There are a variety of artificial methods of birth control, and three of the most common and effective are directly affected by these Illinois provisions. Two methods—the intrauterine device and "the morning-after-pill" (stilbestrol)—are designed to work after fertilization. The former blocks the blastocyst (fertilized egg) from reaching the uterine wall and the latter causes contractions in the uterus that discourage implantation. J. Pritchard & P. MacDonald, Williams Obstetrics 819 (17th ed. 1985); Segal, *Absence of Chorionic Gonadotropin in Sera of Women Who Use Intrauterine Devices*, 44 Fertility and Sterility 214 (1985). The most common and effective birth control is the so-called "pill," which prevents pregnancy primarily by retarding ovulation through the use of hormones. But ovulation is not completely halted by the pill and so fertilization remains a possibility. As an additional set of protections, the pill's hormones also affect the ability of the fertilized egg both to reach the uterus and to implant itself. Mishell, *Control of Human Reproduction: Contraception, Sterilization and Induced Abortion* in Obstetrics and Gynecology 256 (D. Danforth ed. 1982); J. Pritchard & P. MacDonald, Williams Obstetrics 812-813 (17th ed. 1985).

With respect to the definition of "fetus," it is customary to refer to the human conceptus, from fertilization through the first 8 weeks of development, as an *embryo*, and from 8 weeks after ovulation until term, as a *fetus*. J. Pritchard & P. MacDonald, Williams Obstetrics 87 (17th ed. 1985); Kaiser, *Fertilization and the Physiology and Development of Fetus and Placenta*, in Obstetrics and Gynecology 317 (D. Danforth ed. 1982) (setting 11 weeks as the dividing line between embryo and fetus).

2. *Infringement.* Although the abortifacient disclosure requirement does not necessarily implicate a woman's decision whether to have an abortion, it clearly affects the woman's basic ability to make a treatment decision regarding birth control and modifies how the physician can and will consult with the patient. Thus, the law implicates precisely the same core privacy concerns regarding personal decisions about procreation as the laws in *Roe* v. *Wade*, *Griswold* v. *Connecticut*, *and Eisenstadt* v. *Baird*. Thus, under these decisions, the woman clearly has a fundamental privacy right in consultation with her physician to obtain and use an "abortifacient" as defined by Illinois law.

The "abortifacient" provision of Illinois law is obviously designed to, and unquestionably will, intrude into the patient-physician consultation process. The State compels the physician to describe as causing "fetal death" any birth control method which somehow prevents a fertilized egg from becoming implanted in the mother's uterine wall or dislodges the implanted blastocyst. Any effort by the State to dictate precisely what information a physician must convey to the patient involves a direct intrusion into the privacy of the physician-patient relationship. Moreover, by discouraging some women from using birth control, the State increases the health risk to the woman and thereby directly infringes her privacy right. The "risk of dying as the consequence of using an oral contraceptive is certainly less than that imposed by pregnancy and delivery." J. Pritchard & P. MacDonald, Williams Obstetrics 817 (17th ed. 1985).

3. *Compelling Interest Analysis.* Although Section 11(d) primarily regulates the prescription of birth control methods instead of the performance of abortions, the basic framework for evaluating infringements of the woman's privacy right derived from the abortion context applies equally to this provision. Accordingly, Section 11(d) can only be upheld if it is consistent with accepted medical practice and is carefully tailored to serve a compelling state interest. Otherwise this infringement of the woman's fundamental right is unjustified. It is clear that Section 11(d) cannot satisfy these standards. Because

the State did not appeal from the Seventh Circuit's judgment, the Court does not have the benefit of the State's own putative policy justification for enacting Section 11(d). Appellants imply (Br. at 11) that the provision is designed to spare women the trauma of a birth control technique that may cause the non-development or loss of a fertilized egg.

Although the mother's emotional health is unquestionably a legitimate concern to the state (just as it is often a dominant concern to the physician; *see* pp. 38-39, *infra*), it is not compelling unless the health risk the state seeks to prevent is greater than the risk created by compliance with the state's law. *See Roe* v. *Wade*, 410 U.S. at 149; *City of Akron*, 462 U.S. at 435-436. But for those women who forego a birth control method because of the required disclosure, the State's effort plainly increases the health risk to the woman. Moreover, this health risk is far easier to document than the appellants' speculative emotional trauma to a woman caused by nondisclosure of the possible loss of a fertilized egg, which no one can even say ever existed.[31] Thus, the State's interest, which it has chosen not to defend in this appeal, is not a compelling one.

But even assuming the woman's emotional health were a compelling interest of the State in this context, disclosure that invites every patient to believe that she may have an "abortion" if she uses a particular method of birth control is not reasonably related to that goal because it does not comport with accepted medical practices. *Cf.*, Cavanagh & Comas, *Spontaneous Abortion*, in Obstetrics and Gynecology 378 (D. Danforth ed. 1982) (physicians should describe "spontaneous abortion" to patient as "miscarriage" and avoid use of term "abortion" which

[31] *See, e.g.*, Cates, Smith, Rochat & Grimes, *Mortality From Abortion and Childbirth: Are The Statistics Biased?*, 248 J.A.M.A. 192 (1982); Rubin, McCarthy, Shelton, Rochat & Terry, *The Risk of Child Bearing Re-Evaluated*, 71 Am. J. Pub. Health 712 (1981).

upsets patients.) As we explained in the context of Pennsylvania's informed consent statute, not every patient requires disclosure of certain information. Moreover, some women will take offense at the State's way of characterizing the birth control process, and may be particularly offended to have such a description coming from the mouth of their personal physician. *See City of Akron*, 462 U.S. at 445.

Nor is the requirement that the physician describe a birth control method in terms of "*fetal death*" consistent with accepted medical practice. As explained, medicine defines a fetus as being at least 8 weeks old, *see* p. 30, *supra*. *See also* Kaiser, *Fertilization and the Physiology and Development of Fetus and Placenta*, in Obstetrics and Gynecology 317 (D. Danforth ed. 1982) (implanted blastocyst is 0.36 x 0.31 mm). Moreover, describing a fertilized egg as having "died" may not be consistent with many physician's concept of death. Compare *City of Akron*, 462 U.S. at 444. Thus, contrary to appellants' claim (Br. at 16), this law does not prevent deception by the physician; instead, it carries a very serious potential for misleading and frightening unsuspecting women.

Finally, Section 11(d) is not a carefully tailored provision. No law that can be fairly construed to discourage every woman from using the most effective methods of available birth control is even rationally related, much less carefully tailored, to the state's legitimate interest in protecting maternal health. Accordingly, this provision is unconstitutional.[32]

[32] There is an additional basis for holding this law unconstitutional. Section 11(d)'s vagueness directly violates the physician's right to due process. If the State chooses to employ its criminal laws to regulate physician-patient relationships, it must act with greater precision than it has here. No person of ordinary intelligence could do anything but guess as to what disclosures are re-

C. The Illinois and Pennsylvania Provisions Which Require Physicians to Use the Abortion Technique That Will Most Likely Preserve Fetal Life are Unconstitutional.

Section 3210(b) of Pennsylvania's 1982 Abortion Control Act, 18 Pa. Cons. Stat. Ann. § 3210(b) (Purdon 1983), requires the physician who performs an abortion on a fetus known to be viable to use the technique most likely to preserve fetal life unless, in the good-faith judgment of the attending physician, that method would pose a "significantly greater medical risk" to the mother's life or health. The statute expressly excludes potential psychological or emotional effects from the physician's consideration when judging the risk to the woman's life or health. Failure to comply with this section is a third degree felony.

Section 6(4) of the Illinois Abortion Law of 1975, Ill. Rev. Stat. ch. 38, ¶ 81-26(9) (1983), requires a physician who knows that there is a "possibility" of sustained survival by the fetus to employ the same professional skill to preserve the life and health of the fetus that he would be required to exercise toward a fetus intended to be born. Section 6(1) imposes the same requirement of fetal care on the physician, but imposes a harsher criminal penalty if the fetus is "known to be viable." [33]

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quired of him by Section 11(d) in prescribing most birth control methods. *Colautti* v. *Franklin*, 439 U.S. at 400-401.

The claims by the appellants and the United States that the physician "is free to get the message across in any way he chooses" simply highlights the uncertainty of the Illinois law. If the physician knows that the birth control method is an "abortifacient," but attempts "to get the message across" without actually mentioning "fetal death," which is the precise definition contained in the statute, it is not at all clear why a jury could not find that such action constituted a "'reckless" failure to inform the patient that the prescribed method is an abortifacient as statutorily defined. Compare *Colautti* v. *Franklin*, 439 U.S. at 390-394.

[33] The Illinois provisions have been interpreted to require the physician to choose the method of abortion most likely to promote fetal survival. *Wynn* v. *Scott*, 449 F. Supp. 1302, 1321 (N.D. Ill.

1. *Medical Background.* A brief discussion of the medical practices concerning second and third trimester abortions is a necessary backdrop to an analysis of the constitutionality of these laws. "Viability" of the fetus can occur anytime between 22 weeks and 28 weeks after the last menstrual period, although the survival rates for the fetus are "meager" until at least 25 weeks. Hack, Fanaroff & Merkatz, *The Low-Birth-Weight Infant—Evolution of a Changing Outlook*, 301 New Eng. J. Med. 1162, 1164 (1979); Philip, Little, Polivy & Lucey, *Neonatal Mortality Risk for the Eighties: The Importance of Birth Weight/Gestational Age Groups*, 68 Pediatrics 122, 124-125 (1981). *See also City of Akron*, 462 U.S. at 457 n.5 (O'Connor, J., dissenting).

There are two primary abortion procedures during the period surrounding viability—saline amnioinfusion and prostaglandin instillation. Both procedures involve injections by the physician into the amniotic sac surrounding the fetus which cause the uterus to contract and the fetus to be discharged. There are, however, two additional common methods of abortion—hysterotomy, which is much like a "mini" cesarean section for childbirth, and dilatation and evacuation ("D&E"), which involves the use of forceps to evacuate the fetus and suction to ensure that the cavity is empty.[34] Like every medical procedure, these techniques carry their own risks for the mother and have their own effects on the fetus.[35]

1978), *aff'd*, 599 F.2d 193 (7th Cir. 1979). In addition, both statutes have been interpreted not to require the physician to increase the "risk to the woman['s health] to save the fetus." 449 F. Supp. at 1321.

[34] Grimes & Cates, *Dilatation and Evacuation*, in Second Trimester Abortion 127-128 (G. Berger, W. Brenner & L. Keith eds. 1981); Anderson, Gibson & Hobbins, *Obstetric Management of the High Risk Patient*, in Medical Complications During Pregnancy 102 (G. Burrow & T. Ferris 2d ed. 1982).

[35] To simplify matters, we will focus on the four methods of abortion described in the text because they are the most commonly used. In fact, there are other methods. For example, prostaglandin can

Saline amnioinfusion does create a small risk of hemorrhage and infection to the woman, particularly if the abortion is only partially complete.[36] In addition, if the procedure is done incorrectly and the sodium solution gets into the vascular system, it can cause hypernatremia (an excessive increase in the blood sodium level), which in rare instances can be quite serious and even cause death to the mother.[37] Saline amnioinfusion is contraindicated for women with cardio-vascular disease or severe anemias. R. Bolognese & S. Corson, Interruption of Pregnancy—A Total Patient Approach 126 (1975). Saline amnioinfusion is also very likely to result in fetal death; two scientists reported live births at a rate of much less than one per 100 abortions for this procedure. Stroh & Hinman, *Reported Live Births Following Induced Abortion: Two and One-Half Years' Experience in Upstate New York*, 126 Am. J. Obstetrics & Gynecology 83 (1976).

Use of prostaglandins also carries a small risk of hemorrhage and infection, particularly if the placenta is not

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be administered vaginally or even intravenously; also urea can be used instead of, or with, prostaglandins; and a hysterectomy also has been performed in extraordinary circumstances. *See* Bygdeman, *Prostaglandin Procedures*, in Second Trimester Abortion 89, 95-99 (G. Berger, W. Brenner & L. Keith eds. 1981); Kerenyi, *Intra-Amniotic Techniques*, in Abortion and Sterilization: Medical and Social Aspects 369 (J. Hodgson ed. 1981). Each method, of course, carries different risks to the woman depending on her condition.

[36] Kerenyi, *Hypertonic Saline Instillation*, in Second Trimester Abortion 83 (G. Berger, W. Brenner & L. Keith eds. 1981).

[37] *Id.* It is this risk that may make saline amnioinfusion slightly less safe to the mother than use of prostaglandins. Grimes & Cates, *Complication from Legally-Induced Abortions: A Review*, 34 Obstetrical & Gynecological Surv. 177, 188 (1979). *But see* Bygdeman, *Prostaglandin Procedures*, in Second Trimester Abortion 89, 95-99 (G. Berger, W. Brenner & L. Keith eds. 1981) (indicating that prostaglandin caused both more complications and more major complications than saline amnioinfusion). If the saline injection is properly administered, however, the risk to the mother should be about the same with either procedure.

expelled soon after the fetus.[38] There is, however, no risk of hypernatremia. Prostaglandin instillation does have side effects, such as nausea, vomiting and diarrhea.[39] Use of prostaglandin instillation is not recommended for patients with bronchial asthma, other pulmonary problems, glaucoma or epilepsy.[40] Prostaglandin instillation is also quite likely to cause fetal death, but less so than a saline injection; there can be as many as 3 or 4 live births per 100 abortions. Cates & Grimes, *Morbidity and Mortality of Abortion in the United States*, in Abortion and Sterilization 156, 164 (J. Hodgson ed. 1981).[41]

As this Court noted in *City of Akron*, D&E has become the abortion procedure of choice in the early portion of the second trimester. 462 U.S. at 436. But D&E can be used as late as 24 weeks.[42] D&E is generally accepted as

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[38] Kerenyi, *Intra-Amniotic Techniques*, in Abortion and Sterilization: Medical and Social Aspects 359, 367 (J. Hodgson ed. 1981).

[39] *Id.*

[40] Hern, *Mid-Trimester Abortion*, in Obstetrics & Gynecology Ann. 375 (1981); Robins & Surrago, *Alternatives in Mid-Trimester Abortion Induction*, 56 Obstetrics & Gynecology 716 (1980).

[41] *See* American College of Obstetricians & Gynecologists, Tech. Bull. No. 56, *Methods of Midtrimester Abortion* 4 (Dec. 1979); Lee & Baggish, *Live Birth as a Complication of Second Trimester Abortion Induced with Intra-Amniotic Prostaglandin*, 13 Advances in Planned Parenthood 7 (1978); Stubblefield, Noftolin, Frigoletto & Ryan, *Laminaria Augmentation of Intra-Amniotic PGF2 For Midtrimester Pregnancy Termination*, 10 Prostaglandins 413, 420 (1975).

[42] Stubblefield, *Midtrimester Abortion by Curettage Procedures: An Overview*, in Abortion and Sterilization: Medical and Social Aspects 280 (J. Hodgson ed. 1981); Kleiman, *When Abortion Becomes Birth: A Dilemma of Medical Ethics Shaken by New Advances*, N.Y. Times, Feb. 15, 1984, at Bl, col. 1; ACOG, Tech. Bull. No. 56, *Methods of Midtrimester Abortion* (Dec. 1979); Rooks & Cates, *Emotional Impact of D&E* v. *Instillation*, 9 Fam. Plan. Persp. 276-277 (1977). The primary risk caused by later uses of D&E is perforation of the cervix or uterus. Mandelman & Kerenyi, *Medical*

a very safe abortion method and it is also likely to cause the woman much less emotional trouble than the saline amnioinfusion or prostaglandin methods, because it allows the woman to avoid the long and painful labor associated with the other procedures.[43] As the Court pointed out in *Planned Parenthood* v. *Ashcroft*, however, D&E is absolutely fatal to the fetus. 462 U.S. at 483 n.7.

An abdominal hysterotomy is a major surgical procedure and is not accepted as a method of pregnancy termination if any other method is available. J. Pritchard & P. MacDonald, Williams Obstetrics 481-482 (17th ed. 1985). A hysterotomy does no special damage to the fetus, however, and therefore, as a method of pregnancy termination, it provides the greatest likelihood of fetal survival. *See Colautti* v. *Franklin*, 439 U.S. at 398.

2. *Infringement.* Against this background, it is plain that each of the three statutes interferes with the physician's ability to practice medicine on behalf of the patient. With respect to the Pennsylvania law, this Court recognized, even before *Roe* v. *Wade*, *supra*, that the physician's obligation to preserve his patient's health required the physician to consider both the psychological as well as physical well-being of the patient and that judgments concerning both always precede every medical procedure. *United States* v. *Vuitch*, 402 U.S. 62, 72 (1971).[44] Thus, for the State to declare, as Pennsylvania has in enacting

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and Surgical Aspects of Elective Termination, in Rovinsky & Guttmacher's Medical, Surgical and Gynecological Complications of Pregnancy 698 (S. Cherry, R. Berkowitz & N. Kase eds. 1985).

[43] Grimes & Cates, *Dilatation and Evacuation*, in Second Trimester Abortion 128 (G. Berger, W. Brenner & L. Keith eds. 1981).

[44] The importance of the physician's ability to consider all health consequences, including emotional and psychological components, has been repeatedly emphasized by the Court since *Roe* v. *Wade*. *See, e.g.*, *Roe* v. *Wade*, 410 U.S. at 153; *Doe* v. *Bolton*, 410 U.S. at 196; *Beal* v. *Doe*, 432 U.S. 438, 442 (1977); *Colautti* v. *Franklin*, 439 U.S. at 400; *H. L.* v. *Matheson*, 450 U.S. at 397-398, 411.

Section 3210(b), that the physician must ignore emotional and psychological considerations strikes at the core of the physician's duty to provide total treatment for the patient.[45]

In addition, the Court already has held that the physician's primary duty must always be to his patient, the woman. *Colautti* v. *Franklin*, 439 U.S. at 400-401. Here Pennsylvania requires the physician to consider primarily the fetus and be concerned about the patient, only if her physical well-being is "significantly" affected. This, of course, directly regulates, and unquestionably burdens, the physician's provision of medical care to the patient.

Both Sections 6(1) and 6(4) of the Illinois law also directly infringe upon the practice of medicine. They impose upon physicians a burden of care toward the fetus that arises at the time of the abortion procedure itself. While the statutes have been interpreted to give primary concern to the mother's health (*see* note 33, *supra*), they nevertheless affect the decisionmaking process at a critical time for the patient and require the physician to follow statutory criteria rather than professional judgment in deciding upon a course of treatment. In addition, all three provisions attach criminal liability to the determination of "viability" which holds great potential for chilling the physician's medical practices. *Colautti* v. *Franklin*, 439 U.S. at 395. Accordingly, all three statutes infringe upon the fundamental privacy right.

3a. *Compelling Interest Analysis.* To withstand constitutional scrutiny, therefore, each provision must be con-

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[45] *See, e.g.*, Mandelman & Kerenyi, *Medical and Surgical Aspects of Elective Terminations*, in Rovinsky & Guttmacher's Medical, Surgical and Gynecological Complications of Pregnancy 698 (S. Cherry, R. Berkowitz & N. Kase eds. 1985); Laufman, *Surgical Judgment*, in Christopher's Textbook of Surgery 1459 (L. Davis 9th ed. 1968); Nehemiah, *Psychological Aspects of Surgical Practice*, in Surgery: A Concise Guide to Clinical Practice 9 (G. Nardi & G. Zunidema 3d ed. 1972).

sistent with accepted medical practice and be carefully tailored to the states' compelling health interests. Under these standards, none of these state laws is constitutional.

On the merits, the Court can summarily dispose of Section 6(4) of the Illinois Abortion Act. The provision is virtually identical to a Pennsylvania statute declared unconstitutional by this Court in *Colautti* v. *Franklin*, 439 U.S. at 379-380. By requiring the physician to take into account the health of the fetus prior to actual viability, the state law seeks to protect fetal life before the State has any compelling interest in that purpose under this Court's prior rulings. *Roe* v. *Wade*, 410 U.S. at 163. Moreover, imposing duties that distract from the care of the woman is not reasonably related to the State's interest in maternal health. Accordingly, the Illinois provision is patently unconstitutional.[46]

b. Pennsylvania's Section 3210(b) is almost as easily disposed of by this Court on the basis of its prior decisions. Although the statute is properly aimed at preserving fetal life after viability, it is not reasonably related to the State's permissible goals because it is not consistent with accepted medical practice. First, the statute eliminates as a legitimate consideration the mother's emotional health. The absolute elimination of emotional considerations invalidates this statute in light of the Court's repeated insistence that "health" requires consideration of everything relevant to a patient's condition. *See* notes 44 and 45, *supra*.

Moreover, it will be very difficult in any given case for the physician in choosing among abortion methods to make

[46] The abortion method of choice for all pre-viability abortions during the second trimester is or is fast becoming D&E because of the advantages of that procedure to the patient. *See* p. 37, *supra*. Accordingly, to the extent Section 6(4) would impose any restriction upon the physician's decision to choose D&E prior to viability, it would be inconsistent with accepted medical practices and therefore unconstitutional for that additional reason.

the "good faith" judgment Section 3210(b) commands. All methods of abortion at this stage of pregnancy carry risks to the mother, and all but one ordinarily cause the fetus to die. Instead of allowing the mother and physician to evaluate these risks and make a judgment about how best to proceed, Pennsylvania *requires* the physician to make the treatment decision on the basis of a trade-off between maternal and fetal health, which this Court has declared impermissible in both *Colautti* v. *Franklin*, 439 U.S. at 400, and *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485 n.8 (Powell, J.).

The State's analysis in support of this provision is wholly inadequate. The Pennsylvania Attorney General attempts to rewrite the statute so that the physician is not required to favor fetal health over maternal health. By reading the word "significantly" out of the statute, Pennsylvania attempts to avoid the statute's clear inconsistency with accepted medical practices. *Colautti* v. *Franklin*, 439 U.S. at 400; *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485 n.8 (Powell, J.). Concededly, the Court has an obligation to avoid unconstitutional constructions of state law. *See, e.g., Planned Parenthood* v. *Danforth*, 428 U.S. at 64; *Bellotti* v. *Baird*, 443 U.S. at 645 & n.25; *H.L.* v. *Matheson*, 450 U.S. at 406, 407 & n.14, 412. Nevertheless, it must give the statute a "fair" interpretation, and reading a word completely out of the statute, as Pennsylvania proposes, violates a fundamental canon of statutory construction. *See, e.g., McDonald* v. *Thompson*, 305 U.S. 263, 266 (1938); *D. Ginsberg & Sons* v. *Popkin*, 285 U.S. 204, 208 (1932).[47] Accordingly, Section 3210(b) is unconstitutional.

[47] Even if the Court were to accept the Pennsylvania Attorney General's construction of Section 3210(b), it would not preserve the constitutionality of this provision. As we explain later, any statute that imposes a duty on the physician concerning the life of the fetus will necessarily increase the risk to the woman in violation of the accepted medical practice of first protecting the life and health of the mother. *See* pp. 42-43, *infra*.

c. Although Sections 6(4) and 3210(b) can be readily disposed of on the basis of prior decisions of this Court, Section 6(1) poses the basic issue of whether the State, through its criminal laws, can impose upon the physician, who has decided that a post-viability termination of the woman's pregnancy is *necessary* to her life or health, an independent duty to the fetus that arises during the pregnancy termination process.

Amici submit that the State's intrusion into the physician's exercise of judgment in this situation cannot be justified because the physician's primary duty must be to protect the life and health of the mother. Section 6(1) only applies to terminations of pregnancy after the fetus is believed to be viable.[48] Thus, the termination must be necessary to the mother's life or health. One of the main textbooks in the field lists among the "commonly accepted" conditions that warrant a therapeutic abortion: persistent heart disease, advanced hypertensive vascular disease and invasive carcinoma of the cervix. J. Pritchard & P. MacDonald, Williams Obstetrics 477 (17th ed. 1985); Nesbitt & Abdul-Karim, *Coincidental Disorders Complicating Pregnancy*, in Obstetrics and Gynecology 511 (D. Danforth ed. 1982). Obviously, these are conditions that warrant the physician's immediate and dominant concern. *See* H. Barber & E. Graber, Surgical Disease in Pregnancy 697 (1974) (physician's primary concern must be for the mother who has cancer).

It is irrational—and certainly not tailored to any health concerns—for the State to require the physician to give weight to fetal survival in deciding which of the three most common abortion methods to choose when the

[48] No one can "know" when a fetus is viable. The most that a physician could say is that to "a reasonable medical certainty" a fetus has become viable. We agree with the court of appeals that the failure of the state legislature in *1975* to make clear that the viability determination must be made by the physician is fatal to this provision. *See Colautti* v. *Franklin*, 439 U.S. at 391-393.

mother's health or even life is at such extreme risk. All three common methods are *extremely likely* to cause the death of the fetus. *See* pp. 35-38, *supra*. This Court already has recognized that "[m]any" post-viability abortions will "be emergency operations" in which the physician will have to make a very quick judgment concerning which abortion method to choose in light of the mother's particular life or health threatening condition and the physician's own medical skills. *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485 (Powell, J.). As *amici* have already explained, each abortion method carries its own particular risks and those risks must be evaluated in the context of each patient's particular condition. *See* pp. 35-38, *supra*. *Amici* submit that these considerations alone should guide the physician's determination; otherwise, there will always be an increased risk of harm to the mother.

This preference for the mother's health, which this Court has clearly approved, *Colautti* v. *Franklin*, 439 U.S. at 400-401; *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485 (Powell, J.), is particularly warranted because no abortion method even minimally advances the State's interest in fetal health. Except for a hysterotomy which causes a "significantly" greater risk, however defined, to the mother, all other methods will cause fetal death in almost all cases. The fact that prostaglandin instillation is less likely to cause fetal death than saline amnioinfusion (*Colautti* v. *Franklin*, 439 U.S. at 399) should not mask the much more important fact that both methods are *extremely likely* to result in the death of the fetus. Therefore, it makes no medical sense to inject this consideration as a decisive factor into the physician's calculations in choosing how best to treat a seriously ill woman.[49]

[49] Appellants' facile characterization (Br. at 36, 41) of Section 6(1) utterly ignores all medical reality. They assert that the statute merely imposes a duty on a physician, when all other considerations are equal, to decline to choose an abortion method that is injurious

Amici do not mean to suggest that the State cannot enact laws to serve its compelling interest in the survival of the fetus. The State can protect that interest by requiring the physician who performs an abortion after viability to certify that the abortion was necessary to protect the mother's life or health, *Roe* v. *Wade*, 410 U.S. at 163-164, *and* by requiring hospitals, when appropriate, to take measures, such as use of a second physician, to assist the infant who survives the termination of pregnancy. *Ashcroft*, 462 U.S. at 485-486. These measures are tailored to the State's compelling interest and do not interfere with the physician's judgment at a critical time in the woman's treatment. Because Section 6(1), by contrast, is clearly inconsistent with sound medical practice, it is not reasonably related to the State's permissible health goals and is thus unconstitutional.

D. Pennsylvania's Second-Physician Requirement Must Contain An Exception For Emergency Abortions.

Section 3210(c) of Pennsylvania's 1982 Abortion Control Act, 18 Pa. Cons. Stat. Ann. § 3210(c) (Purdon 1983), requires the mother's attending physician to arrange for a second physician to be in attendance if the chosen method of abortion "does not preclude the possi bility of the child surviving the abortion. . . ." The purpose of the second physician is to take control of the child and become his or her primary provider of care.

In *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485-486, this Court upheld a provision in the Missouri abortion statute that imposed a somewhat similar second-physician requirement. The Court, however, required that the statute contain a clear exception to the requirement of a second physician whenever the abortion was an emergency procedure. When the mother's health is at risk, the

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to the fetus. What this assumes is that all other considerations will be equal. But this is not consistent with medical practice. The physician's concern is and should be with the mother until after the mother's life or health are no longer in jeopardy. *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485 (Powell, J.).

attending physician's concern should be exclusively on the mother and not be distracted by the need to obtain a second physician before going ahead with the needed medical care. *Id.* For the reasons stated by the Court in *Ashcroft*, *amici* strongly support the importance of an emergency exception. Thus, Section 3210(c) is only constitutional if the statute somewhere contains a clear emergency exception.

Pennsylvania asserts that the affirmative defense provision in its statute, § 3210(a), which bars conviction if the physician concluded in good faith that the abortion was necessary to preserve the mother's life or health, can be interpreted as an emergency exception to the second-physician requirement. But, Pennsylvania's law is not as clear as Missouri's statute in *Ashcroft*; Section 3210(a) says nothing specifically about the second physician and it is a *defense* to a criminal prosecution for performing an abortion on a post-viable fetus and not part of the second-physician requirement itself. Accordingly, *amici* submit that the court of appeals properly held that the provision was insufficiently clear and thereby correctly required a more carefully drafted emergency exception.

E. Pennsylvania's Abortion Reporting Requirement Is Unconstitutional.

Section 3214 of Pennsylvania's 1982 Abortion Control Act, 18 Pa. Cons. Stat. Ann. § 3214 (Purdon 1983), requires every physician who performs an abortion to report certain information to the State. Within a month of the procedure, the physician must submit a report that specifies the referring physician, agency or service; the facility where the abortion was performed; the political subdivision and state in which the woman resides; her age, race and marital status; the number of her prior pregnancies; the date of her last menstrual period; the "probable gestational age of the unborn child"; the type of abortion procedure performed; any complications; the "length and weight of the aborted unborn child when measurable"; the basis for any judg-

ment that the abortion was required because of a medical emergency; and the basis for the physician's determination that the fetus was not viable or that a post-viability abortion was necessary to preserve the mother's life or health. 18 Pa. Cons. Stat. Ann. §§ 3211, 3214 (Purdon 1983). Failure to provide this information is a first degree misdemeanor; in addition, failure to provide information about viability constitutes "unprofessional conduct," and will result in at least a three-month suspension of the physician's medical license.

1. *Infringement.* This Court already has held that a state can require physicians to supply it with routine reports concerning each abortion because such reports ordinarily constitute "minor" regulation of the physician's practices and the reports reasonably further the state's interest in health by providing the state with aggregate data regarding various abortion procedures. *Planned Parenthood* v. *Danforth*, 428 U.S. at 80. But this Court in *Danforth* made clear that such reports could not regulate the physician's judgment or be too burdensome, *id.* at 80-81, and reiterated this point in *City of Akron*, 462 U.S. at 430 n.13 (recordkeeping is permissible "if not abused or overdone. . .").

Amici do not object to reporting requirements if they are restricted to factual material about each abortion which are carefully tailored to a legitimate state goal. Physicians routinely fill out reports for states, such as death certificates and child abuse and drug abuse reports. M. Lewis & C. Warden, Law and Ethics in the Medical Office Including Bioethical Issues 56-58 (1983). Unlike the routine forms required in those contexts, Pennsylvania demands that a physician explain in writing the bases for his judgment about the viability of a fetus and his choice of abortion procedure. These reports are therefore not limited to routine factual materials. Moreover, the physician must supply this information without the slightest idea what use the State may make of it and without being given guidance regarding the level of detail which the State expects or wants.

Thus, the State's requirement seems intended to discourage physicians from performing abortions and will have that effect by requiring them to devote time to drafting reports, under vague criteria, that could better be spent treating patients. J.S. App. at 79a-81a; *Cf.*, *Parham* v. *J.R.*, 442 U.S. 584 (1979) (psychiatrist time better spent practicing medicine than testifying at commitment hearings). In addition, the State's requirement will increase the cost to a woman who has an abortion as opposed to any other medical procedure; the abortion procedure is uniquely burdened by the State's reporting requirement of a physician's professional "judgments."

2. *Compelling Interest Analysis.* Pennsylvania's reporting provision is invalid because it is not carefully tailored to a compelling state interest. The Pennsylvania Attorney General asserts that these reports could be a source of data that could be used for research. (Pa. Br. at 60-61.) But the statute nowhere mentions how these reports will be used by the State, and no legislative history is cited to show that the legislature intended the judgmental portions of the reports to be used for any purpose other than to burden the physician. Nor does the Attorney General attempt to suggest, even in theory, how unstructured answers describing professional judgments underlying a physician's treatment decisions can be used as a data base for serious scientific research by the State or anyone else.

In sum, when a state seeks to force physicians to report on the basis for the exercise of their medical judgment, the state must show that its use of reported information is carefully tailored to the state's interest in maternal health, and Pennsylvania cannot satisfy that requirement because of the vagueness of its requirement and the lack of any rational connection, much less a carefully tailored one, to the state's interest in advancing maternal health.

CONCLUSION

For the reasons stated above, the judgments of the courts of appeals should be affirmed.

Respectfully submitted,

Of Counsel:

KIRK B. JOHNSON
AMERICAN MEDICAL ASSOCIATION
535 N. Dearborn Street
Chicago, Illinois 60610
(312) 645-4600

R. MICHAEL MILLER
AMERICAN ACADEMY OF FAMILY PHYSICIANS
1740 West 92nd Street
Kansas City, Missouri 64114
(816) 333-9700

STEPHAN E. LAWTON
PIERSON, BALL & DOWD
1200 - 18th Street, N.W.
Washington, D.C. 20036
(202) 331-8566

JOEL I. KLEIN
ONEK, KLEIN & FARR
2500 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184

JOSEPH A. KEYES, JR.
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
One Dupont Circle, N.W.
Washington, D.C. 20036
(202) 828-0555

ANN E. ALLEN
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
600 Maryland Avenue, S.W.
Suite 300-East
Washington, D.C. 20024
(202) 638-5577

BENJAMIN W. HEINEMAN, JR.*
CARTER G. PHILLIPS
VINCENT F. PRADA
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 429-4000

NEWTON N. MINOW
JACK R. BIERIG
One First National Plaza
Chicago, Illinois 60603
(312) 853-7000

SIDLEY & AUSTIN
Counsel for the Amici Curiae

* Counsel of Record

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